		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045831

Facility Name: St Anthony's Continuing Care

Address: 767 30th Street (Number) Rock Island (City) 61201 (Zip Code)

County: Rock Island

Telephone Number: (309)788-7631 **Fax #** (309)788-9823

IDPA ID Number: 260040256001

Date of Initial License for Current Owners: 7/1/02

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501C3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Tricia Bergien **Telephone Number:** (612) 991-6519

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2002 to 6/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Kevin Rymanowski
(Title) Director - Budget & Financial Analysis

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,001	2,585	2,715	11,301	8
9	SNF/PED					9
10	ICF	15,639	7,876	580	24,095	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,640	10,461	3,295	35,396	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.81%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Employee and Guest Meals

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/02 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 2,679

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/03 Fiscal Year: 6/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Anthony's Continuing Care # 0045831 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	222,856	22,532	5,501	250,889	200	251,089		251,089			1
2	Food Purchase		164,787		164,787		164,787	(320)	164,467			2
3	Housekeeping	132,909	13,854		146,763		146,763		146,763			3
4	Laundry	20,335	4,449	120,084	144,868		144,868		144,868			4
5	Heat and Other Utilities			247,321	247,321	(204)	247,117	(6,718)	240,399			5
6	Maintenance	167,694	34,257	73,636	275,587	(8,491)	267,096	(5,753)	261,343			6
7	Other (specify):*					8,470	8,470		8,470			7
8	**TOTAL General Services**	543,794	239,879	446,542	1,230,215	(25)	1,230,190	(12,791)	1,217,399			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	1,550,560	(21,057)	343,114	1,872,617		1,872,617		1,872,617			10
10a	Therapy	13,888	940	130,770	145,598		145,598		145,598			10a
11	Activities	63,650	3,938	9,450	77,038		77,038		77,038			11
12	Social Services	53,073	131	250	53,454		53,454		53,454			12
13	Nurse Aide Training											13
14	Program Transportation			523	523		523	(523)				14
15	Other (specify):* **Inservice Director**	33,885			33,885		33,885		33,885			15
16	**TOTAL Health Care and Programs**	1,715,056	(16,048)	505,707	2,204,715		2,204,715	(523)	2,204,192			16
	C. General Administration											
17	Administrative	55,212		315,803	371,015		371,015	13,708	384,723			17
18	Directors Fees											18
19	Professional Services			28,983	28,983		28,983	(14,678)	14,305			19
20	Dues, Fees, Subscriptions & Promotions			28,070	28,070	130	28,200	(9,682)	18,518			20
21	Clerical & General Office Expenses	136,528	39,740	15,435	191,703		191,703		191,703			21
22	Employee Benefits & Payroll Taxes			649,067	649,067		649,067	7,797	656,864			22
23	Inservice Training & Education			50	50		50		50			23
24	Travel and Seminar			10,250	10,250	(105)	10,145	(6,891)	3,254			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			80,184	80,184		80,184	(93)	80,091			26
27	Other (specify):* **See MA Groupings**			850,050	850,050		850,050	(850,050)				27
28	**TOTAL General Administration**	191,740	39,740	1,977,892	2,209,372	25	2,209,397	(859,889)	1,349,508			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,450,590	263,571	2,930,141	5,644,302		5,644,302	(873,203)	4,771,099			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Anthony's Continuing Care #0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			2,128	2,128		2,128	312,532	314,660			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,039	6,039		6,039	2,682	8,721			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,641	8,641		8,641		8,641			35
36	Other (specify):*											36
37	**TOTAL Ownership**			16,808	16,808		16,808	315,214	332,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		150,477		150,477		150,477		150,477			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,519	66,519		66,519		66,519			42
43	Other (specify):*			3,053	3,053		3,053		3,053			43
44	**TOTAL Special Cost Centers**		150,477	69,572	220,049		220,049		220,049			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,450,590	414,048	3,016,521	5,881,159		5,881,159	(557,989)	5,323,170			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(79)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(241)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,000)	27		24
25	Fund Raising, Advertising and Promotional	(9,682)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(535,978)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (595,980)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	37,991	various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 37,991		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (557,989)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Anthony's Continuing Care

ID# 0045831

Report Period Beginning: 7/1/2002

Ending: 6/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Employee Benefits	$ (1,677)	22	1
2	Capitalize Underground Drainline	(3,867)	6	2
3	Legal Related to Acquisition	(14,028)	19	3
4	Accouting Related to Acquisition	(650)	19	4
5	Travel & Seminars Outside Il, Not Patient Care Rel.	(6,891)	24	5
6	Travel & Seminars Outside Il	(523)	14	6
7	Rented Facility Space - Beauty Shop	(288)	5	7
8	Rented Facility Space - Beauty Shop	(311)	6	8
9	Rented Facility Space - Beauty Shop	(93)	26	9
10	Rented Facility Space - Beauty Shop	(396)	30	10
11	Adjust Depreciation to Straight Line	337,737	30	11
12	Depreciation of Non-Care Related Assets	(36,936)	30	12
13	Non-Care Related Utilities	(6,430)	5	13
14	Remove Contributions	(50)	27	14
15	Remove Extraordinary Expense	(800,000)	27	15
16	Capitalize Boiler Repair	(1,575)	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(535,978)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Anthony's Continuing Care # 0045831 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(320)	0	0	0	0	0	0	0	0	0	0	(320)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(6,718)	0	0	0	0	0	0	0	0	0	0	(6,718)	5
6	Maintenance	(5,753)	0	0	0	0	0	0	0	0	0	0	(5,753)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(12,791)	0	0	0	0	0	0	0	0	0	0	(12,791)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(523)	0	0	0	0	0	0	0	0	0	0	(523)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(523)	0	0	0	0	0	0	0	0	0	0	(523)	16
	C. General Administration													
17	Administrative	0	13,708	0	0	0	0	0	0	0	0	0	13,708	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,678)	0	0	0	0	0	0	0	0	0	0	(14,678)	19
20	Fees, Subscriptions & Promotions	(9,682)	0	0	0	0	0	0	0	0	0	0	(9,682)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(1,677)	9,474	0	0	0	0	0	0	0	0	0	7,797	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(6,891)	0	0	0	0	0	0	0	0	0	0	(6,891)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(93)	0	0	0	0	0	0	0	0	0	0	(93)	26
27	Other (specify):*	(850,050)	0	0	0	0	0	0	0	0	0	0	(850,050)	27
28	**TOTAL General Administration**	(883,071)	23,182	0	0	0	0	0	0	0	0	0	(859,889)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(896,385)	23,182	0	0	0	0	0	0	0	0	0	(873,203)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Anthony's Continuing Care # 0045831 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	300,405	12,127	0	0	0	0	0	0	0	0	0	312,532	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,682	0	0	0	0	0	0	0	0	0	2,682	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	300,405	14,809	0	0	0	0	0	0	0	0	0	315,214	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(595,980)	37,991	0	0	0	0	0	0	0	0	0	(557,989)	45

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Benedictine Health System	100%	See attached schedule		See attached schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Salary - Administrator	$ 55,212	Benedictine Health System	100.00%	$ 55,212	$	1
2	V	22	Executive Flex Benefits	10,697	Benedictine Health System	100.00%	20,171	9,474	2
3	V	17	Computer User Fee	40,800	Benedictine Health System	100.00%	81,669	40,869	3
4	V	17	Management Fee	150,000	Benedictine Health System	100.00%	140,855	(9,145)	4
5	V		Detail: Administrator, Budgeting, Bookkeeping, Accounting, Operational Policies, Regulatory Assistance, Communications Support						5
6	V	30	Depreciation		Benedictine Health System	100.00%	6,315	6,315	6
7	V	32	Interest		Benedictine Health System	100.00%	1,239	1,239	7
8	V	17	Mutual Support Fees (See Line 5)	125,003	Benedictine Health System	100.00%	106,987	(18,016)	8
9	V	30	Depreciation		Benedictine Health System	100.00%	5,812	5,812	9
10	V	32	Interest		Benedictine Health System	100.00%	1,443	1,443	10
11	V								11
12	V								12
13	V								13
14	Total			$ 381,712			$ 419,703	$ * 37,991	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Benedictine Health System
Street Address: 503 East Third Street, Suite 400
City / State / Zip Code: Duluth, MN 55805
Phone Number: (218-786-2370
Fax Number: (218-786-2373

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Please refer to the BHD and BHS Home Office Cost Reports for detail.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Wells Fargo		X	Line of Credit		4/14/03,5/7/03	450,000		rolled to commer paper		2,020	6
7	BHS/SMDC Master Trust Indenture		X	Commercial Paper		2/13/03	300,000	750,000	rolls every	variable	4,019	7
8	Debt Discount		X	Commercial Paper		6/30/03	2,461	2,461	3 months	variable		8
9	**TOTAL Facility Related**						$ 752,461	$ 752,461			$ 6,039	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 752,461	$ 752,461			$ 6,039	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ None** **Line # N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Anthony's Continuing Care **#** 0045831 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ N/A	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Anthony's Continuing Care COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0045831

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 149,308 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Care Related	319,300	7/1/2002	$ 250,000	1
2					2
3	TOTALS	319,300		$ 250,000	3

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		2002	1974	$ 5,551,185	$	3-30 yrs	$ 177,608	$ 177,608	$ 5,117,610	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements 1990			1990	17,305		5-15 yrs	673	673	15,790	9
10	Building Improvements 1991			1991	89,794		10-20 yrs	1,475	1,475	78,071	10
11	Building Improvements 1992			1992	49,923		6 yrs	2,239	2,239	31,453	11
12	Building Improvements 1993			1993	385,598		5-18 yrs	20,136	20,136	268,643	12
13	Building Improvements 1994			1994	1,361		5-17 yrs	49	49	985	13
14	Building Improvements 1995			1995	99,722		5-16 yrs	9,356	9,356	76,980	14
15	Building Improvements 1996			1996	757,621		5-20 yrs	41,232	41,232	311,858	15
16	Building Improvements 1997			1997	137,756		5-20 yrs	9,296	9,296	56,753	16
17	Chapel Sound System			1998	2,853		10 yrs	285	285	1,355	17
18	Upgrade Water Service			1998	559		20 yrs	28	28	133	18
19	Automatic Door - Ambulance Entrance			1998	10,975		10 yrs	1,098	1,098	5,214	19
20	Emergency Generator			1999	283,366		20 yrs	14,168	14,168	48,404	20
21	Sprinkler System - Fire Alarm			2000	6,981		10 yrs	698	698	2,036	21
22	Sprinkler System			2000	424,156		20 yrs	21,208	21,208	61,856	22
23	Sprinkler System			2001	1,221		20 yrs	61	61	137	23
24											24
25	Carriage House Parking Lot Lights			1996	528		15 yrs	35	35	238	25
26	Carriage House Parking Lot Lights			1997	24,480		8-15 yrs	2,968	2,968	17,065	26
27	Land Improvements - Hospital			1990	29,461		5-10 yrs			29,461	27
28	Land Improvements - Hospital			1993	5,789		10 yrs	434	434	5,789	28
29	Land Improvements - Hospital			1997	30,405		8-15 yrs	3,574	3,574	20,552	29
30											30
31	Building Improve-Repair Underground Drainline (Exp on G/L)			2002	3,867		20 yrs	161	161	161	31
32	Building Improve-Boiler Repair (Exp on G/L)			2003	1,575		20 yrs	39	39	39	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,916,481	$		$ 306,822	$ 306,822	$ 6,150,584	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 328,955	$ 1,786	$ 32,701	$ 30,915	3-20 yrs	$ 209,339	71
72	Current Year Purchases	4,789	342	342	0	7 yrs	342	72
73	Fully Depreciated Assets	553,262					553,262	73
74								74
75	TOTALS	$ 887,006	$ 2,128	$ 33,043	$ 30,915		$ 762,943	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,053,487	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,128	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 339,865	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 337,737	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,913,527	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Chapel/Storage	$ 415,615	$ 13,854	$ 406,228	86
87	Riverside Annex	692,467	23,082	676,717	87
88	Carriage House Assets	65,188		65,188	88
89	Chapel Window	5,771		5,771	89
90	Chapel Paint	7,240		7,240	90
91	TOTALS	$ 1,186,281	$ 36,936	$ 1,161,144	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 1 & 2	1213 hrs	13,888			940	1,213	14,828	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 13,888		$	$ 940	1,213	$ 14,828	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Anthony's Continuing Care **#** 0045831 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 128,921	$	1
2	Cash-Patient Deposits	24,654		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,000)	814,623		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,792		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 989,990	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	29,789		16
17	Accumulated Depreciation (book methods)	(2,128)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 27,661	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,017,651	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,089,798	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,696		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	154,245		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Insurance Reserves	41,661		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,298,400	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	750,749		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Unearned Revenue	500,000		43
44	Restricted Funds Payable	240		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,250,989	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,549,389	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,531,738)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,017,651	$	48

***(See instructions.)**

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,531,738)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,531,738)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,531,738)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,009,938	1
2	Discounts and Allowances for all Levels	(1,563,915)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,446,023	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	375,749	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 375,749	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,963	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,542	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,400	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,127	19
20	Radiology and X-Ray	1,220	20
21	Other Medical Services	464,880	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 475,132	23
	D. Non-Operating Revenue		
24	Contributions	51,218	24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,220	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous (See attached schedule)	1,297	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,297	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,349,421	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,230,215	31
32	Health Care	2,204,715	32
33	General Administration	2,209,372	33
	B. Capital Expense		
34	Ownership	16,808	34
	C. Ancillary Expense		
35	Special Cost Centers	153,530	35
36	Provider Participation Fee	66,519	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,881,159	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,531,738)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,531,738)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,161	4,672	$ 99,582	$ 21.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,107	12,236	239,108	19.54	3
4	Licensed Practical Nurses	23,716	26,811	395,515	14.75	4
5	Nurse Aides & Orderlies	65,033	72,793	717,140	9.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,008	1,213	13,888	11.45	7
8	Rehab/Therapy Aides	2,112	2,284	53,079	23.24	8
9	Activity Director					9
10	Activity Assistants	6,422	7,224	63,650	8.81	10
11	Social Service Workers	3,504	3,966	53,073	13.38	11
12	Dietician	25,391	28,749	222,856	7.75	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	14,246	16,241	167,694	10.33	17
18	Housekeepers	15,546	17,322	132,909	7.67	18
19	Laundry	2,090	2,410	20,335	8.44	19
20	Administrator	2,080	2,223	55,212	24.84	20
21	Assistant Administrator					21
22	Other Administrative	9,005	10,136	136,528	13.47	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,740	3,142	37,579	11.96	31
32	Other Health C: Staff Develop &	2,340	2,560	42,442	16.58	32
33	Other(specify) Central Supply					33
34	TOTAL (lines 1 - 33)	190,501	213,982	$ 2,450,590 *	$ 11.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	214	$ 5,501	1.3	35
36	Medical Director	monthly fee	21,600	9.3	36
37	Medical Records Consultant	12	345	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly fee	600	10.3	39
40	Physical Therapy Consultant	1,901	63,662	10.3	40
41	Occupational Therapy Consultant	1,999	61,243	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	198	5,865	10.3	43
44	Activity Consultant	8	450	11.3	44
45	Social Service Consultant	4	250	12.3	45
46	Other(specify)	semi-monthly	9,000	11.3	46
47		fee			47
48					48
49	TOTAL (lines 35 - 48)	4,336	$ 168,516		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	330	$ 13,385	10.3	50
51	Licensed Practical Nurses	3,226	116,622	10.3	51
52	Nurse Aides	9,891	212,163	10.3	52
53	TOTAL (lines 50 - 52)	13,447	$ 342,170		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eileen Moseley	Administrator	0	$ 55,212
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,212

B. Administrative - Other

Description	Amount
Computer User Fee	$ 40,800
Management Fee	150,000
Mutual Support Fee	125,003
TOTAL (agree to Schedule V, line 17, col. 3)	$ 315,803
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher Law Offices	Legal	$ 4,140
Johnson, Killen, & Seiler, P.A.	Legal	10,403
Rock Island County	Legal	250
Larson Allen	Accounting	1,400
The Raymond Group	Professional Fees	2,427
Sisters of the Third Order	Professional Fees	9,003
Ernst & Young	Accounting	1,360
(After adjustments, legal fees is less than $2,500. Therefore, no legal invoices are attached.)		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,983

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 53,493
Unemployment Compensation Insurance	
FICA Taxes	172,445
Employee Health Insurance	304,275
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Unemployment Tax	56,138
Group Life Insurance	6,251
Group Dental Insurance	34,024
Group Disability Insurance	10,067
Executive Flex Benefits	20,171
Other Employee Benefits	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,864

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 105
Advertising: Employee Recruitment	11,389
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network & AAHSA	4,918
IL Nursing Home Admin Assoc	75
Subscriptions	1,711
Bank Service Charges	61
Dietary Managers Association	234
Charitable Org Annual Report Filing Fee	25
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,518

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,057
Seminar Expense	2,197
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,254

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Anthony's Continuing Care # 0045831 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network & AAHSA $4,918

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 7,324 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? NO If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 66,519
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Beauty Shop For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? YES Indicate the amount. $ 79

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Ernst and Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. Not Available-Will submit when issue

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.